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TREASURE STATE HEALTH

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NEW CASES OF ACTIVE TUBERCULOSIS CONTINUE TO OCCUR IN MONTANA

In 1964 there were 120 new cases of active tuberculosis found in Montana and 133 in 1965! It is well known that any case, if not found and treated could spread the disease to others. The "know-how" to eradicate tuberculosis is available and an intensified effort is being made in Montana to eradicate this disease. This announcement was made by Mary E. Soules, M. D., M. P. H., disease control director on the State Board of Health staff.

Clyde Draughon, M. D., began employment as the director of the eradication program on October 17th. Dr. Draughon came to the State Board of Health staff following private practice in general surgery and medicine in Helena and Topeka, Kansas. He received his medical degree from the Oklahoma School of Medicine in Oklahoma.

Intensified efforts to eradicate tuberculosis were begun in Silver Bow County several months ago with two public health nurses added to the staff of the Health Department. Within recent months funds have been made available to employ an additional public health nurse in both the Missoula and Great Falls Health departments, and one has been added to the Yellowstone County Nursing staff. A bacteriologist will be added to the Board's microbiology staff to absorb the increasing demand for laboratory services in the control program. With this increased number of professional staff, efforts to eradicate tuberculosis become more realistic.

Tuberculosis in Montana*

In 1964 Montana's new active tuberculosis rate was 17.1** which is below that of the nation as a whole the rate is 26.6. However, there were 15 States with rates lower than Montana's the lowest being 6.5 in Iowa.

The death rate in 1964 in Montana was 4.0, which almost equals the national rate for that year which was 4.3.

The accompanying maps show there has been little change in the areas of Montana where the case rates are high. It will be noted that most of these areas coincide with the counties adjacent to Indian Reservations and in the hard rock mining area of the State.

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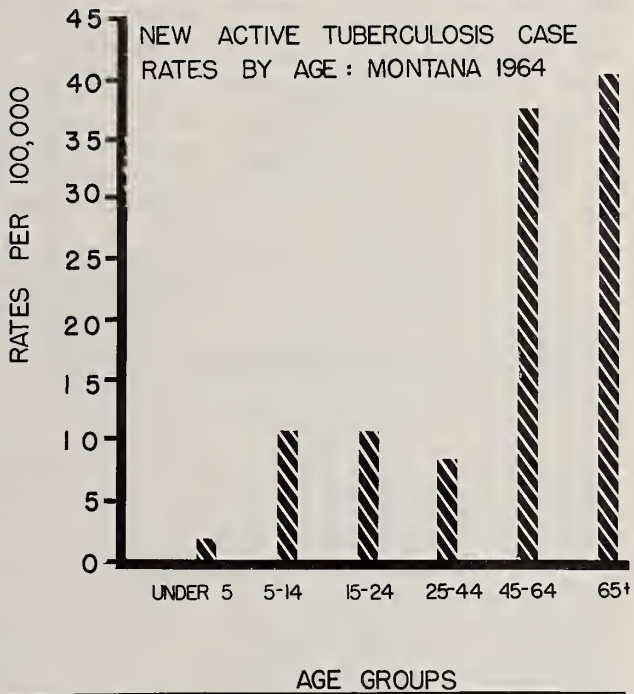
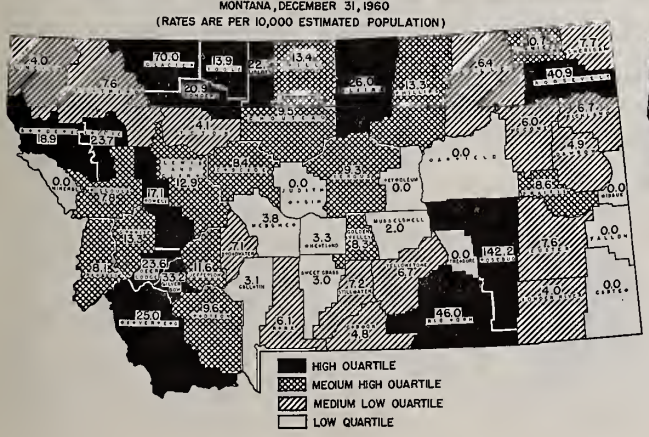


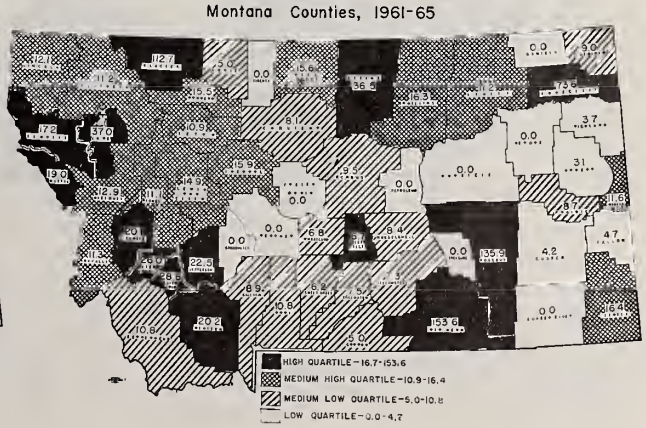
*1964 statistics are used in this article, unless otherwise stated, since these are the most recent statistics available for the nation.

**Tuberculosis rates are the cases per 100,000.

COUNTY RATES FOR CASES IN THE TUBERCULOSIS CASE REGISTER
MONTANA, DECEMBER 31, 1960
(RATES ARE PER 10,000 ESTIMATED POPULATION)



FIVE-YEAR ACTIVE TUBERCULOSIS CASE RATES:
Montana Counties, 1961-65



TUBERCULOSIS ERADICATION

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A number of studies have shown that there are certain factors which increase the risk of developing active tuberculosis in a susceptible population. These factors are **race, sex, age** and **socio-economic status.**

The **racial differences** in Montana, which are also influenced by socio-economic conditions, are striking. The new active tuberculosis case rate among whites is 10.2 as compared with the non-white rate of 184.8. The total number of cases reported was 120, of which 51 were non-white. That is, 42½% were in the non-white population which is only about 3% of the total population. The non-white population in Montana is chiefly Indian.

The Division of Indian Health of the Public Health Service has its headquarters in Billings and has professional health staff on each of the reservations. The intensive efforts in tuberculosis control among the Indian people living on the reservations in the State are continuing by this agency. There is a high degree of cooperation between this agency and the State Board of Health—essential since many of the Indians move back and forth between the reservations and Montana communities.

Sex differences are usually found with rates for males higher than for females. This is the case among whites in Montana where the rate for males was 15.4 and for females 4.8. However, this is not the case among non-whites in the State where the rates are about even—males 182.5 and females 187.1.

The highest rates of active tuberculosis are usually found among the **older age groups.** The graph on page one shows this is true in Montana

Tuberculosis Control

A good tuberculosis control program is geared to finding every case of tuberculosis early and getting each under treatment and with continuing medical supervision. Another basic facet of the program is to find the contacts of each patient and get them tested and examined if necessary, and under treatment when positively diagnosed.

Finding early cases of tuberculosis is accomplished, in addition to locating the contacts, by periodic mass skin testing in areas of high incidence for selected groups and x-raying the positives. Selected groups include children prior to their entrance to school, school children at about the age of 14; families of the reactors are also tested as is school personnel. Among the high risk groups in the population are those such as silicotics and nursing home patients where mass testing is encouraged. Medical diagnostic services, including laboratory tests, are sought for those with suspect x-rays. In some areas of the State, according to plans for the program, tuberculosis clinics will be held.

The public health staff makes every effort to help patients understand their condition and motivate them to cooperate fully in the prescribed treatment. The staff assists patients in making arrangements for hospitalization when necessary and provides supervision of care for those at home.

After medical discharge patients are followed for at least five years through semi-annual physical examinations and other procedures as indicated in an effort to prevent relapse.

Continuing Education

Opportunities will be provided for the professional staff in the program to take advantage of short-term courses to bring them up-to-date in the ever changing procedures in treatment, and follow-up in tuberculosis control.

It is hoped that education of the public can be accelerated since many persons have become complacent about continuing efforts in tuberculosis control as the tuberculosis cases and death rates have decreased. However, there is no place for complacency as long as new cases of tuberculosis and deaths from tuberculosis occur in Montana.

Reorganization of PHS Effective January 1st

The current organization of the Public Health Service is expected to become effective about January 1, 1967. This announcement was made by John W. Gardner, Secretary of the Department of Health, Education, and Welfare.

The reorganization of the Service into five bureaus was recommended by William Stewart, M. D., Surgeon General, following a year-long study by experts from within and outside the Federal government. Its purpose is to create a strong Public Health Service, tuned to the health needs of our time and organized to deliver its full measure of the Federal commitment of health, Secretary Gardner said.

The five-Bureau structure with their newly-assigned divisions are as follows:

1. **Bureau of Health Services.** This combines the direct medical programs of the Service with its activities related to the development of health facilities and the delivery of community health services. It includes the divisions of: direct health services, health mobilization, hospital and medical facilities, medical care administration, community health services, Federal Employee occupational health and safety, Indian health, and mental retardation.

2. **Bureau of Health Manpower.** This Bureau brings together programs of support for the education and training of urgently needed health professionals and supporting personnel.

3. **Bureau of Disease Prevention and Environmental Control.** The purpose of this bureau is to combine activities in the control of communicable and chronic diseases, injuries resulting from accidents, and hazards of the modern environment.

4. **Bureau of Mental Health.** The national institute of mental health has been made a bureau to provide a strong central resource for research community services designed to conquer mental illness. It contains the division with programs in extramural research manpower and training, mental health service, special mental health programs, field investigations. This bureau also includes the mental health intramural research programs with division of clinical, behavioral, and biological research programs and the division of special mental health research.

5. **The National Institutes of Health,** the primary biomedical research arm of the Federal government will be augmented by the addition of a new division of environmental health sciences. It includes the National Institutes of allergy and infectious diseases, arthritis and metabolic diseases, cancer, child health and human development, dental research, general medical sciences, heart neurological diseases and blindness. Also included are the divisions of biologics standards, research facilities and resources, research grants, regional medical programs, research services, computer research and technology, environmental health sciences and the clinical center.

To coordinate and direct these programs, and setting overall policy for the Public Health Service, the Surgeon General's office will be strengthened and expanded.

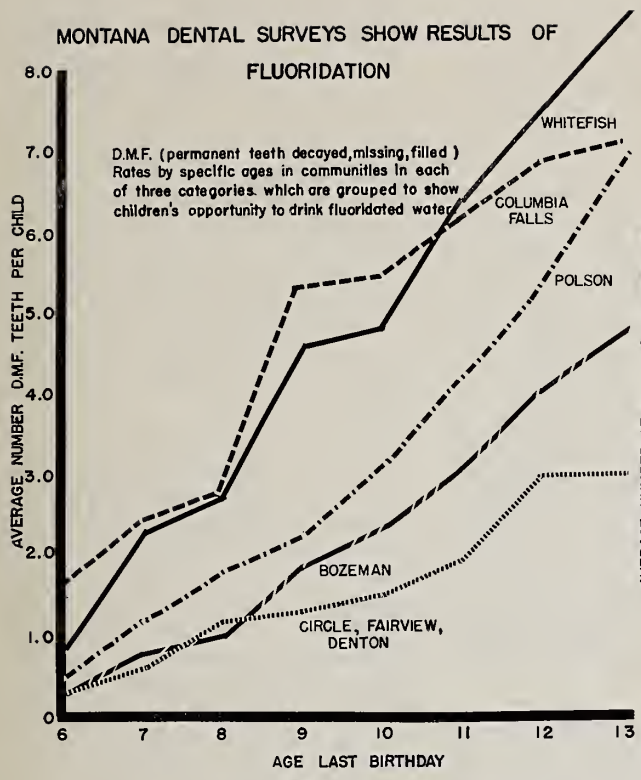

Fig. 1

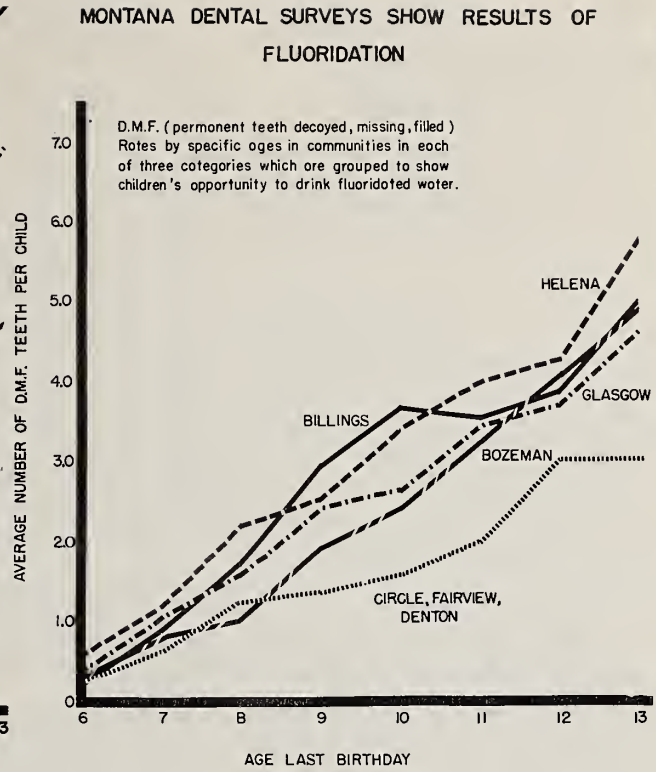

Fig. 2

BENEFITS OF FLUORIDATION SHOWN IN DENTAL SURVEYS

There are five communities in Montana with a total population of approximately 34,000 on water supply systems with controlled fluoride in the amount of 1.2 parts per million (ppm). This amount is recommended for the partial control of dental decay. These towns are Bozeman, Conrad, Laurel, Miles City and Roundup, John R. Snyder, D.D.S., M. P. H., dental health director of the State Board of Health, has announced. Dental surveys in several of these communities have shown a reduction in tooth decay of almost two-thirds. There are two predominately Indian communities that have completed plans to begin this health measure. They are St. Ignatius and Poplar.

In addition there are 45 Montana communities (Great Falls being the largest) with a population of over 100,000 and some private water supplies that have an adequate amount of natural fluoride which brings the population having this opportunity to 37.1%.

The benefits of an adequate amount of fluoride in the public water supplies in the partial control of dental decay in some Montana communities are shown on the accompanying graphs.

Fig. 1 shows the survey results in Whitefish, Columbia Falls and Polson where the public water supplies have only a trace of natural fluoride. These reults are compared with those in Bozeman and a composite score for Circle, Denton and Fairview. At the time of the Bozeman survey, there had been a controlled fluoride program of 1.2 ppm fluorides in the public water supply for 10 years. The water supplies of Circle, Denton and Fairview have a natural fluoride content varying from 1.2 to 3.6 ppm.

Fig. 2 shows the results of surveys in Helena where the fluoride content of public water supply from three different sources ranges from 0.0 to 0.4 ppm; in Billings, where the average fluoride content is 0.4 ppm with the water supply coming

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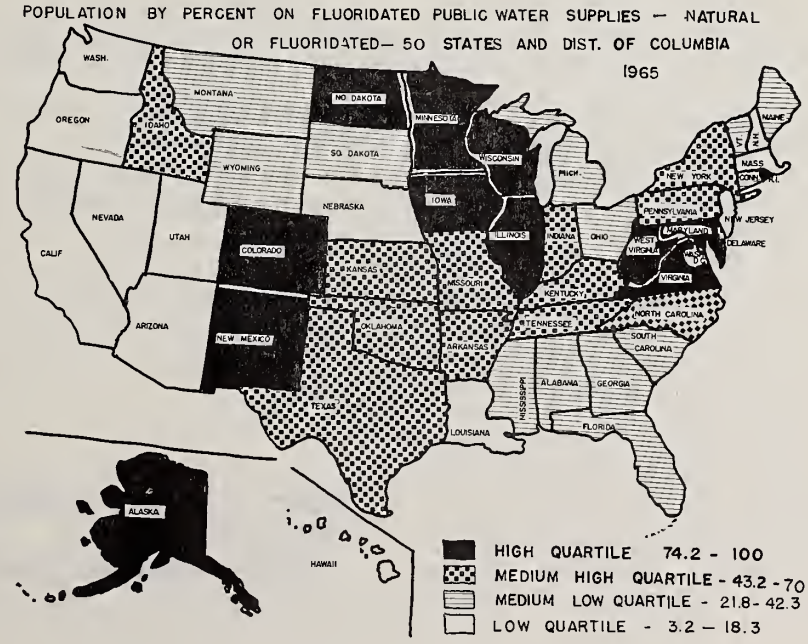

Montana's Public Health Expenditures Among Lowest in the Nation

Information compiled by the Public Health Service shows that Montana's expenditures for public health were low compared to other States. The tabulation was for the 1965 fiscal year.

Per capita expenditures for public health services averaged $4.10 while Montana's per capita expenditures were $2.96 with only twelve States lower. The expenditures ranged from a low of $2.29 in South Dakota to $10.94 in Alaska.

Montana was shown to rank 29th in per capita income in 1965 ($2,-438) and expended $0.65 for public health services for $1,000 of personal income. Only Nebraska, Iowa and South Dakota spent less on this basis. All but 20 States spent more than $1.00 per $1,000 personal income.

In one category Montana ranks first and that is in using a higher percentage of Federal funds in the total public health expenditures than did any other State.

FLUORIDATION BENEFITS

(Continued from page 3)

from the Yellowstone River; and in Glasgow where the water supply comes from three different wells with 0.5 ppm fluoride content. These are compared with the composite score of Circle, Denton and Fairview and Bozeman.

Status in the Nation

The map on page three shows the percentage of the population in each of the 50 States and the District of Columbia which has the advantage of a fluoridated public water supply—(either natural or controlled fluoridation). The percentage ranges from 3.2% to 100%. It will be noted Montana, with 37.1% is in the medium low quartile.

The American Dental Association reports that at the close of 1965 there were 3,030 communities with 1,692 water systems fluoridating. During the 1965 year 272 new communities began controlled fluoridation, the largest of which was New York City. There are ten of the other major cities in the country with controlled water fluoridation in the public water supplies. They are San Francisco, Minneapolis, St. Paul, Denver, Chicago, Philadelphia, Detroit, Baltimore, Cleveland, Washington, D. C. and St. Louis.

. . . To Strike a Balance

Farmers must use pesticides if they are to produce food crops. Yet, the concentration of the pesticides must not be so great that human health is endangered. Factories such as lumber mills dispose volatile wastes into the atmosphere, again the concentration of these wastes must not be hazardous to human health.

The environment in which people live is constantly changing, either being improved or downgraded—depending upon what is going on. Obviously, it is impossible to go back to the times of the Indian tribes when people could move as their campsites were no longer clean. **"To strike a balance"** is the public health goal today. Other states with a greater population density face more serious environmental problems than does Montana, and fortunately Montana still has a chance to correct many of these problems before they become more serious.

Montana needs legislation to control air pollution and stronger legislation to control the use of pesticides so that human health can be protected. This legislation while protecting the public health must allow for the needs of industry. Advisory committees have been formed to study both of these problems and to advise not only on proposed legislation, but on the guidelines needed by the public health staffs to enforce such legislation.

Coming Events . . . .

Nov. 3-4—Montana Dietitic Association, Bozeman.

Nov. 5—Advisory Council to Joint Committee Between State Department of Public Instruction and SBH, Helena.

April 20-22—Montana Tuberculosis Association, Lewistown.

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Crippled Childrens' Clinics

A total of 443 children were seen at six crippled childrens' clinics during the past few months. Of these children, there were 219 who were new to the program and the remaining made return visits. The clinics were held in Great Falls, Billings, Havre, Cut Bank, Miles City and Whitefish. Clinics were held last fall in Conrad, Glasgow, Sidney, Hamilton and Bozeman. To each clinic children from the area surrounding the clinic site are provided clinic services.

Steps are underway to control the disposal of solid wastes or garbage. The last legislature approved a law which requires plans for the disposal area which must be reviewed and approved by the SBH. Many communities have already established satisfactory disposal areas and are utilizing proper disposal methods. Others are acquiring land and developing plans for setting up proper areas. Improperly situated and operated dumps provide harborage for rats and fly breeding places. In some instances garbage is illegally dumped into rivers, thus polluting the stream.

Montana has an enviable record in the control of stream pollution, with 96% of the sewered population meeting the minimum requirements of sewage treatment. Yet, there are 23 communities with minimum treatment facilities that do not meet these requirements and work is underway to correct this situation. Furthermore, some of the treatment facilities are not being operated effectively and it is desirable that the operators take advantage of the training that is offered, especially those in small communities.

Montana's Food and Drug law needs to be up-dated and an improved program developed so that the illegal sale of drugs, misbranding of food and drugs and the adulteration of food and drugs can be controlled; and so that the sanitation of food and drug manufacturing establishments can be improved and food poisoning more adequately prevented.

As the population of the State grows, the establishments of new industry increases and the tourist industry becomes growing importance, Montanans must prevent health hazards from developing before it is too late.

SECOND CLASS POSTAGE PAID AT HELENA, MONTANA